Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hand and Wrist Center of Houston

Respondent Name
Amerisure Partners Insurance Company

MFDR Tracking Number
M4-15-1542-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The healthcare provider's position on this claim is that the services have been underpaid. We find that none of the services billed on the claim were paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code."

Amount in Dispute: $178.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the Medical Fee Dispute … the original billed CPT Code 97003 was not paid due to incorrect billing.

As noted on original EOR Review #7701917 and reconsideration EOR Review #7947044 & 8127945 EFFECTIVE FOR THERAPY CLAIMS WITH DOS ON OR AFTER JULY 1, 2013 G-CODES (G8978-G8999, G9158-G9176 AND G9186) ARE REQUIRED WITH SEVERITY/COMPLEXITY MODIFIER (CH-CN). THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY REQUIRE FUNCTIONAL REPORTING G CODE WHEN CPT CODE(S) 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92164, 92616, 96105, 96125, 97001, 97002, 97003, 97004 ARE BILLED.

The HCP did not bill with required G Code. No additional reimbursement is due."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2014	Occupational Therapy Evaluation (97003)	$178.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication.
   - W3 – Additional payment made on appeal/reconsideration.
   - Note: Effective for therapy claims with DOS on or after July 1, 2013 G-Codes (G8978-G8999, G9158-G9176 and G9188) are required with severity/complexity modifier (CH-CN). This non-payable code is for required reporting only. Require Functional Reporting G-Code when CPT Code(s) 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 are billed.

Issues

1. What is the correct rule for evaluation of the disputed services?
2. Did the requestor bill the disputed services according to 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The requestor references 28 Texas Administrative Code §134.202 as the reason the disputed services should be paid. However, 28 Texas Administrative Code §134.203 (a) states, "… (2) This section applies to professional medical services provided on or after March 1, 2008. (3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies." Review of the submitted documentation finds that the disputed services relate to a charge on date of service August 6, 2014. Therefore, the correct rule for evaluation of the disputed services is 28 Texas Administrative Code §134.203.
2. 28 Texas Administrative Code §134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The disputed services involve charges for an Occupational Therapy Evaluation (CPT Code 97003). The Medicare Claims Processing Manual, Chapter 5, relating to Part B Outpatient Rehabilitation and CORF/OPT Services §10.6 (G) states, in relevant part, "Functional reporting using the G-codes and corresponding severity modifier is required reporting on specified therapy claims. Specifically, they are required on claims: … When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes … 97003 …) is furnished and billed." This requirement was "effective for therapy services with dates of service on and after January 1, 2013" [§10.6 (B)]. Review of the submitted documentation finds that billed CPT Code 97003 was not accompanied by non-payable functional reporting G-Codes and appropriate severity/complexity modifiers. Therefore, the disputed services were not billed according to 28 Texas Administrative Code §134.203.
3. The Medicare Claims Processing Manual, Chapter 5 §10.6 (B) states, in relevant part, "Claims for therapy services furnished on and after July 1, 2013, that do not contain the required functional G-code/modifier information will be returned or rejected, as applicable." Therefore, the Division recommends no reimbursement for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	March 25, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.